Date ____________ Patient Name (First) ________________(Middle)___ (Last) ____________________ (Nickname)_______
Address ____
City ______________________________ State __________ Zip ________________
Date of Birth ____________________________ SSN __________________________ Sex (F) _____ (M) _____
Married ____ Single ____ Child ____ Email Address ____
Phone (Cell) _________________________ (Work) _________________________ (Home) __________________________
Emergency Contact Name & Phone Number ____

Please make sure to give us any updated insurance information you may have when checking in. Thanks.

HEALTH HISTORY (please indicate "yes" or "no")

Y N		Y N		Y N	
○ ○	AIDS/HIV	○ ○	Cortisone/Steroid Treatment	○ ○	High Blood Pressure
○ ○	Anxiety/Nervous Problems	○ ○	Diabetes (circle) type 1/type 2	○ ○	Kidney Disease
○ ○	Asthma	○ ○	Drug/Alcohol Abuse	○ ○	Liver Disease
○ ○	Blood Disorder	○ ○	Emphysema/Respiratory Disease	○ ○	Low Blood Pressure
○ ○	Anemia	○ ○	Epilepsy	○ ○	Migraines/Frequent Headaches
○ ○	Other ___________	○ ○	Fainting/Dizziness	○ ○	Premedicate (prior dental procedure)
○ ○	Blood Thinners (i.e.-Coumadin, Warfarin, Aspirin)	○ ○	Fen-Phen (Diet Pills)	○ ○	Psychiatric Care
○ ○	Bones/Joints	○ ○	Heart Problems	○ ○	Rheumatic Fever
○ ○	Arthritis/Rheumatism	○ ○	Artificial Heart Valves	○ ○	Scarlet Fever
○ ○	Artificial Joints	○ ○	Congenital Heart Lesions	○ ○	Skin Rash
○ ○	Other ____________	○ ○	Heart Disease	○ ○	Stroke
○ ○	Cancer (type) ___________	○ ○	Heart Murmur	○ ○	Thyroid Problems
○ ○	Chemotherapy	○ ○	Mitral Valve Prolapse	○ ○	Tuberculosis
○ ○	Radiation Therapy	○ ○	Pacemaker	○ ○	Tumor
○ ○	Cold Sores/Fever Blisters/Herpes	○ ○	Other ________________	○ ○	Weight Loss, unexplained
		○ ○	Hepatitis (type)____________	○ ○	Eating Disorder

Physician's Name ____ Phone (_____) ______________________________

Have you had any recent surgeries/hospitalizations? (past 5 years) ______________________________________

ALLERGIES

Y N
○ ○ Aspirin
○ ○ Barbiturates (Sleeping Pills)
○ ○ Codeine
○ ○ Flavoring Agents (i.e.-Mint/Cinnamon)
○ ○ Iodine
○ ○ Latex
○ ○ Local Anesthetics/Epinephrine
○ ○ Penicillin
○ ○ Sulfa
○ ○ Other _________________________
____

WOMEN: Are you pregnant? Y N Due Date?____________
Are you nursing? Y N Taking Birth Control? Y N

MEDICATIONS

Please list any medications you are currently taking and reason:

____
____
____

Have you ever been told you needed an antibiotic prior to dental treatment? (Circle one) YES NO

Preferred Pharmacy ___________________________________
____

You agree, in order for us to service your account or to collect any amounts you may owe, our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. Our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency may also contact you by sending text messages or emails, using any e-mail address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lendor/Creditor, its ancillary providers, HIPAA business associates, vendors, and its debt collection agents may contact me/us as described above.

I acknowledge that if I do not give 24 hours notice of cancellation (by phone call) , I am responsible for a $50 cancellation fee (subject to change).

I acknowledge that I (the patient), am responsible to know my insurance benefits, and benefits are not guaranteed until the insurance company has made payment.

I acknowledge that payment is due when services are rendered.

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for this activities and health care operations that are related to treatment.

Patient's / Parent's Signature ____ Date ________________________